Filing at a Glance

Company:	Continental American Insurance Company
Product Name:	Hospital Indemnity 8500
State:	Arkansas
TOI:	H14G Group Health - Hospital Indemnity
Sub-TOI:	H14G.000 Health - Hospital Indemnity
Filing Type:	Form
Date Submitted:	11/05/2012
SERFF Tr Num:	CAIC-128756126
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	9109
Implementation Date Requested:	On Approval
Author(s):	Sara McCormick
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	11/05/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity 8500
Project Name/Number: Enrollment Form /

General Information

Project Name: Enrollment Form
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Other
Overall Rate Impact:

Deemer Date:
Submitted By: Sara McCormick

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Explanation for Other Group Market Type: Union
Filing Status Changed: 11/05/2012
State Status Changed: 11/05/2012
Created By: Sara McCormick
Corresponding Filing Tracking Number:

Filing Description:

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130
TOI: H14G Group Health – Hospital Indemnity
Sub-TOI: H14G.00 Health – Hospital Indemnity
Proposed Effective Date: On Approval
Domicile State Approval: SC – Pending
Form: CAI8516.1AR Enrollment Form

Dear Sir or Madam:

The above-captioned form is being filed for your review and approval. This is a new filing and will not replace any other forms on file with your department.

The enrollment form will be used with group hospital indemnity forms approved by your department.

If you have any questions or require additional information, please contact Sara McCormick either at 1.888.730.2244, ext. 4952 or at companycompliance@aflac.com. Thank you for your consideration in this matter.

Company and Contact

Filing Contact Information

Sara McCormick, Regulatory Analyst
2801 Devine Street
Columbia, SC 29205

smccormick@caicworksite.com
803-354-4952 [Phone]

Filing Company Information

Continental American Insurance Company
2801 Devine Street
Columbia, SC 29205
(803) 256-6265 ext. [Phone]

CoCode: 71730
Group Code:
Group Name: Continental Amer Ins Co
FEIN Number: 57-0514130

State of Domicile: South Carolina
Company Type: LAH
State ID Number:

Filing Fees

State: *Arkansas* ***Filing Company:*** *Continental American Insurance Company*
TOI/Sub-TOI: *H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*
Product Name: *Hospital Indemnity 8500*
Project Name/Number: *Enrollment Form /*

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	As South Carolina's domiciliary fee is $0, we are submitting Arkansas' fee of $50.00/application filing.
Per Company:	No

Company	Amount	Date Processed	Transaction #
Continental American Insurance Company	$50.00	11/05/2012	64558017

SERFF Tracking #:	*CAIC-128756126*	***State Tracking #:***		***Company Tracking #:***	*9109*

State:	*Arkansas*	***Filing Company:***	*Continental American Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity 8500*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/05/2012	11/05/2012

SERFF Tracking #:	*CAIC-128756126*	***State Tracking #:***		***Company Tracking #:***	*9109*

State:	*Arkansas*	***Filing Company:***	*Continental American Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity 8500*		
Project Name/Number:	*Enrollment Form /*		

Disposition

Disposition Date: 11/05/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Variability Statement	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

SERFF Tracking #:	*CAIC-128756126*	***State Tracking #:***		***Company Tracking #:***	*9109*

State:	*Arkansas*	***Filing Company:***	*Continental American Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity 8500*		
Project Name/Number:	*Enrollment Form /*		

Form Schedule

Lead Form Number: CAI8516.1AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/05/2012	Enrollment Form	CAI8516.1AR	AEF	Initial		0.000	CAI8516.1AR Hospital Indemnity Enrollment Form.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[Aflac]

CONTINENTAL AMERICAN INSURANCE COMPANY

ENROLLMENT FORM

Please Mail: [Post Office Box 427
Columbia, South Carolina29202
800.433.3036]

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Hospital Indemnity		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY				
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **Newly Eligible**	☐ **Re-Submission**

Deduction start date _____

[Employee] Name/Certificate Holder (First, MI, Last)	**Social Security Number/ID Number**	**Gender**	**Date of Birth**
Street Address	**City**	**State**	**ZIP**
[Employer]	**Job Class/Occupation**	**Location**	**Hire/Change of Status Date**

Hours Worked	**Daytime Phone Number ( )**	**Spouse's Name (if coverage is requested)**	**Gender**	**Spouse Date of Birth**

[[Employee] Height / Weight]	**[Spouse Height / Weight]**

	[Employee]	**Spouse**
[Are you currently working [part-time;full-time] for the [employer] listed above?]	☐ **YES** ☐ **NO**	
[Are you now disabled or unable to work?]		☐ **YES** ☐ **NO**

[List all eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name	**Gender**	**Date of Birth**	**Name**	**Gender**	**Date of Birth**
					]

HOSPITAL INDEMNITY Plan:_____ [Section 125: ☐ Yes ☐ No]

[☐ New Coverage] [☐ Change in Coverage]

☐ [Employee] [☐ [Employee] & Spouse] [☐ [Employee] & Children] [☐ Family] ***Cost per pay period:*** $_____

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [$x.xx].]

		[Employee]	**Spouse**	**Children**
[1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) high blood pressure, resulting in your now taking 3 or more medications for treatment?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**
[4	Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO]**

To the best of my knowledge and belief, the answers to the questions on this Enrollment Form are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

[Does this coverage replace any existing Aflac individual policy? ☐ **YES** ☐ **NO]**
Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**

If yes, provide carrier and policy number: _____

[If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.]

Coverage will not become effective unless you are employed [part-time; full-time] on the enrollment date and on the effective date.

CERTIFICATION: I have read the completed Enrollment Form and I realize any false statement or misrepresentation in the Enrollment Form may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Enrollment Form is approved and the necessary premium is paid.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

[I authorize [my employer] to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.]

[I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work].]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____Agent No._____ State of Enrollment_____

[

Things to Consider Before Replacing Your Existing Insurance Coverage

Aflac's goal is to provide you with outstanding insurance products that offer important financial protection to you and your loved ones in the event of an accident or illness. To best serve our customers, we offer a robust portfolio of products designed to respond to a variety of needs and circumstances. If you are thinking about replacing one type of policy for another, please be aware that there are important differences between insurance products—specifically group products versus individual products. These differences may affect your coverage. Before making a change to any existing coverage you may have, please make sure to carefully compare the benefits provided by your existing policy and the proposed replacement coverage. Among the items you should consider are the following:

1. If you are currently receiving treatment for an injury or illness: Your new coverage will not cover claims for treatment received as a result of injuries or illnesses diagnosed prior to its effective date.
2. If you terminate existing coverage, no benefits will be paid for diagnoses or treatments you receive after the termination date.
3. Benefits of your existing policy and the replacement coverage you're considering may be different, and you may be subject to new waiting periods and/or coverage exclusions due to preexisting conditions.
4. If you terminate an existing policy, you will lose any accrued benefits. Any such accrued benefits cannot be transferred to new coverage.
5. Individual insurance coverage is guaranteed-renewable and cannot be cancelled for any reason other than non-payment of premium.
6. Group insurance coverage is not guaranteed-renewable. If the master policy held by your employer or organization is cancelled, your coverage terminates.
7. Individual insurance coverage is fully portable. If you leave your current job, you can retain your individual insurance coverage.
8. Group coverage has limited portability. If you change jobs, you may not be able to retain your coverage.

By signing below, I acknowledge that I have received this notice and wish to apply for new coverage.

Signature of Applicant_____ Date_____

Applicant's Name (printed)_____

Address (printed)_____

E-Mail Address_____ Telephone_____]

SERFF Tracking #:	*CAIC-128756126*	***State Tracking #:***	***Company Tracking #:*** *9109*

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Product Name:	*Hospital Indemnity 8500*		
Project Name/Number:	*Enrollment Form /*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	11/05/2012
Comments:	This application form will be used with policy forms approved by your department with a Flesch score which meets or exceeds your minimum requirements.		

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	11/05/2012
Bypass Reason:	This is an application-only filing.		

		Item Status:	**Status Date:**
Satisfied - Item:	Variability Statement	Approved-Closed	11/05/2012
Comments:			
Attachment(s):			
CAI8551 Enrollment Form Variability Statement.pdf			

CONTINENTAL AMERICAN INSURANCE COMPANY

VARIABILITY STATEMENT:
GROUP HOSPITAL INDEMNITY FORM

ENROLLMENT FORM (CAI8516.1AR)

Variable information is bracketed ***throughout the form**** as follows:	
Throughout the document, **[Employee]** is bracketed.	**[Employee/Member]** applies to each occurrence.
Throughout the document, **[Employees]** is bracketed.	**[Employees/Members]** applies to each occurrence.
Throughout the document, **[Employees']** is bracketed.	**[Employees'/Members']** applies to each occurrence.
Throughout the document, **[full]** is bracketed.	**[full/part]** will indicate whether the group's employees are full- or part-time. It will be available based negotiations with the prospective policyholder and his needs.
Please note: Bracketed items listed above are NOT highlighted or explained elsewhere in this variability statement. Additional bracketed items outlined ***individually***:	
[Aflac]	[The Aflac logo is variable so that necessary changes to the logo can be incorporated.]
[2801 Devine Street, Columbia, South Carolina 29205 800.433.3036]	[The address is variable so necessary changes can be incorporated.]
[Employer]	[This will reflect the type of group – can be replaced with terms employer, policyholder, association, union]
[Employee Height / Weight] [Spouse Height / Weight]	[Sections are bracketed so they can be removed according to the coverage the group has chosen. Sections will be removed for guaranteed issue situations.]
[Are you currently working [part-time;full-time] for the [employer] listed above?] [Are you now disabled or unable to work?]	[Eligibility Questions: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.]
HOSPITAL INDEMNITY [Section 125: ☐ Yes ☐ No] [☐ New Coverage] [☐ Change in Coverage] ☐ [Employee] [☐ [Employee] & Spouse] [☐ [Employee] & Spouse]] ☐ [Family]	[Section 125, New or Change in Coverage: will be either included or deleted from the form based on negotiations with the prospective policyholder and his needs.]

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [$x.xx].]	[Types of coverage can be removed if all types are not offered to a group.] [Provision can be removed depending on account administration.] [Frequency can be changed depending on account administration.] [The correct fee for the individual certificate holder will be included.]
1. [1 Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?] 2. [2 In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.] 3. [3 Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) high blood pressure, resulting in your now taking 3 or more medications for treatment?] 4. [4 Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?]	[Questions are bracketed so they can be removed according to the coverage the group has chosen. Questions will be removed for guaranteed issue situations.]
[Does this coverage replace any existing Aflac individual policy? ☐ YES ☐ NO]	[Statement will either be included or deleted based on the needs of the prospective policyholder.]
[If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.]	[Statement will be either included or deleted from the enrollment form based on the needs of the prospective policyholder]
[I authorize [my employer] to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.]	[Can be adjusted to reflect a different payment method if applicable.] [Policyholder]
[I certify that I currently work [part-time; full-time] for the [employer] listed on this enrollment form [and that my spouse is not currently disabled or unable to work].]	[Either included or deleted from the enrollment form based on the needs of the prospective policyholder]
[**Things to Consider Before Replacing Your Existing Insurance Coverage**]	[The Disclosure page titled "Things to Consider Before Replacing Your Existing Insurance Coverage", will be either included or deleted from the enrollment form based on the needs of the prospective

	policyholder.